PATIENT AUTHORIZATION FOR APPOINTMENT REMINDERS AND SCHEDULING RELATED MATTERS

It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to remind you about scheduled appointments. re-evaluations or other appointment related issues. The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information use your decision will have no adverse effect on your care from our office or on your relationship with our staff.

Your signature indicates your authorization of this activity.

_____ _____

Name(printed) Signature **Date**

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

Can we have your permission to discuss any information pertaining to your care with anyone of your household?

Yes _____ No _____

If Yes, who? _____ Relationship_____

_____ Relationship_____

Signature_____ Date_____